**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-987-3705 or (401) 429-2104 or TDD 711 or visit us at www.BCBSRI.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-987-3705 or TDD 711 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For In Network providers **$500** for an individual plan / **$1000** for a family plan.<br>For Out-of-Network providers **$1000** for an individual plan / **$2000** for a family plan. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes.<br>Doesn't apply to most preventive services, services with a fixed dollar copay, ambulance services and diagnostic tests. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No | You don't have to meet deductible for specific services. |
| **What is the out-of-pocket limit for this plan?** | For In Network providers **$1000** for an individual plan / **$2000** for a family plan.<br>For Out-of-Network providers **$5000** for an individual plan / **$10000** for a family plan. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.BCBSRI.com or call 1-866-987-3705 or (401) 429-2104 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No | You can see the specialist you choose without a referral. |

- All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 copay; deductible does not apply per visit | 30% coinsurance | Telemedicine visit: $15 copay; deductible does not apply. If you receive services in addition to office visit, additional deductibles or coinsurance may apply. |
| | Specialist visit | $25 copay; deductible does not apply per visit | 30% coinsurance | $15 copay; deductible does not apply for Chiropractic Services. |
| | Preventive care/screening/immunization | No Charge; deductible does not apply | 30% coinsurance | Member liability for In Network is based on services received. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. For additional details, please see your plan documents or visit www.BCBSRI.com/providers/policies |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge; deductible does not apply | 30% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.BCBSRI.com. | Tier 1 generally low cost generic drugs | Retail: $10 Copay<br>Mail Order: $20 Copay | Retail: $10 Copay<br>Mail Order: N/A | Pharmacy coverage administered by CVS Caremark. Deductible does not apply to prescription drug copays. Retail-31 days/Mail Order-90 days. Specialty Tier 1 Drugs are covered at Tier 1 level. |
| | Tier 2 generally high cost generic and preferred brand name drugs | Retail: $35 Copay<br>Mail Order: $70 Copay | Retail: $35 Copay<br>Mail Order: N/A | |
| | Tier 3 non-preferred brand name drugs | Retail: $60 Copay<br>Mail Order: $120 Copay | Retail: $60 Copay<br>Mail Order: N/A | |
| | Tier 4 specialty prescription drugs | Retail: $100 Copay<br>Mail Order: Not Covered | Not Covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply |
| **If you need immediate medical attention** | Emergency room care | $125 copay; deductible does not apply per visit | $125 copay; deductible does not apply per visit | Emergency room: Copay waived if admitted;<br>Urgent care: Applies to the visit only. If additional services are provided additional out of pocket costs would apply based on services received |
| | Emergency medical transportation | No Charge; deductible does not apply per trip | No Charge; deductible does not apply per trip | |
| | Urgent care | $50 copay; deductible does not apply per urgent care center visit | 30% coinsurance | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | See www.employeebenefits.ri.gov for list of services requiring prior authorization.<br>Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply. |
| | Physician/surgeon fee | 10% coinsurance | 30% coinsurance | Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $15 copay; deductible does not apply/office visit<br>10% coinsurance for outpatient services | 30% coinsurance/office visit<br>30% coinsurance for outpatient services | None |
| | Inpatient services | 10% coinsurance | 30% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | $15 copay/initial visit only; deductible does not apply | 30% coinsurance | Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 30% coinsurance | No visit limit. Custodial, domiciliary and respite care are not covered. Prior authorization required. |
| | Rehabilitation services | $15 copay; deductible does not apply | 30% coinsurance | Certain services for a Dependent child younger than 3 years of age who is certified by the RI Department of Human Services (DHS) as eligible for early intervention services. Services must be provided by a licensed provider designated by the RI DHS as an "early intervention provider" and who works in early intervention programs approved by the RI Department of Health. Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply. |
| | Habilitation services | $15 copay; deductible does not apply | 30% coinsurance | |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | Non-Network requires prior authorization; Custodial care is not covered |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | Non-Network prior authorization required for certain services; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge, deductible does not apply. |
| | Hospice service | 10% coinsurance | 30% coinsurance | No visit or dollar limit. Non-network prior authorization required. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | Medically necessary exams: In Network: $25 copay; deductible does not apply, Out of Network: 30% coinsurance |
| | Children's glasses | Not Covered | Not Covered | None |
| | Children's dental check-up | Not Covered | Not Covered | None |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up, child
- Glasses, child
- Long-term care
- Prescription Drugs
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Child)
- Routine foot care unless to treat a systemic condition
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Most coverage provided outside the United States. Contact Customer Service for more information.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for us and those agencies is: the plan at 1-866-987-3705 or (401) 429-2104 or TDD 711, state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: contact the plan at 1-866-987-3705 or (401) 429-2104 or TDD 711. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact your state insurance department at (401) 462-9520 or by email at HealthInsInquiry@ohic.ri.gov.

**Does this plan provide Minimum Essential Coverage? No.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards? No.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## Language Access Services:

Para obtener asistencia en Español, llame al 1-866-987-3705.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-987-3705.

**如果需要中文的帮助**，请拨打这个号码 1-866-987-3705.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-987-3705.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $20 |
| Coinsurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | **$1,090** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $3,800 |
| **The total Joe would pay is** | **$4,400** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | **$710** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.